



SUTTER PHYSICIANS ALLIANCE (SPA)
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SPA PCP Treatment & Referral Guidelines
ENT

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I. Neck Mass

A) Evaluation

- a) Distinguish between inflammatory and non-inflammatory. (80% of non-inflammatory, non-thyroid neck masses are malignant in adults).
- b) Look for other associated problems (tonsil, dental, etc...)
- c) Note location: unilateral vs. bilateral; midline, anterior triangle, posterior triangle.
- d) Note history of cat scratch.

B) Labs

- a) CBC, thyroid studies, PPD, HIV, and others as indicated.

C) Radiographs

- a) CT may be considered if deep abscess is suspected.

D) Management Options

- a) For inflammatory: Augmentin or Clindamycin
- b) Oral surgery referral for dental problems

E) Referral Guidelines

- a) Refer all non-inflammatory masses except perhaps documented multinodular goiter or hyperfunctioning nodule.
- b) Refer if mass persists greater than two (2) weeks without improvement.
- c) Progressive enlargement.
- d) Suspicion for metastatic disease.

What should accompany the referral:

- a) all labs
- b) radiographs

F) Comments:

- a) Have a high index of suspicion for smokers with unilateral mass, even in the absence of other symptoms.
- b) Fine needle aspiration is only diagnostic when positive. Fine needle aspirate interpreted as benign does not rule out the possibility of more sinister pathology.
- c) Pediatric neck masses are usually inflammatory or congenital cysts.

II. Dysphagia (Cervical, Esophageal, or Pharyngeal)

A) Evaluation / Consider

- a) Foreign body ingestion
- b) GERD
- c) Esophageal motility disorder
- d) Scleroderma
- e) Neoplasm
- f) Thyromegaly
- g) Cervical osteophytes
- h) Globus

- B) Labs
 - a) Thyroid studies, immune studies if indicated
- C) Radiographs
 - a) Soft tissue neck (foreign body), chest x-ray and / or Barium Swallow
- D) Management Options
 - a) Anti-reflux measures
 - b) Lifestyle; PPI
- E) Referral Guidelines
 - a) Suspected foreign body
 - b) Dysphagia in children
 - c) Symptoms associated with hoarseness
 - d) Persistent symptoms despite medical management.
 - e) Symptoms associated with weight loss, aspiration or hemoptysis
- F) Comments
 - a) Reflux is very common cause for “lump in the throat Dysphagia.”

III. Tinnitus

- A) Evaluation
 - a) Evaluate for cerumen, otitis, middle ear fluid or mass.
 - b) History of hearing loss, trauma, noise exposure.
 - c) Tuning fork test, audiogram
 - d) Auscultate the neck, ear, or skull for pulsatile tinnitus.
 - e) TMJ evaluation
- B) Management Options
 - a) Clean ears for Cerumen
 - b) Treat otitis
 - c) Audiogram
 - d) Monitor medications such as salicylates.
- C) Referral Guidelines
 - a) Unilateral Tinnitus
 - b) Pulsatile Tinnitus
 - c) Tinnitus associated with vertigo, hearing loss or other neurologic symptoms.
- D) Comments
 - a) Monitor alcohol, tobacco, caffeine & sodium use.
 - b) Minimize noise exposure
 - c) Consider TMJ as a possible cause
 - d) Consider white noise machine masking while sleeping if significant pathology has been ruled out.

IV. External Otitis

- A) Evaluation

- a) Physical exam: significant pain, tenderness, swelling
Often ear canal is too swollen to allow adequate TM evaluation.

B) Labs

- a) Culture of the ear canal often shows Pseudomonas or fungus

C) Radiographs

- a) Not generally helpful

D) Management Options

- a) Topical: Cortisporin drops
- b) Tobramycin or Gentamycin drops
- c) Cipro drops
- e) Add Lotrimin solution if fungal infection suspected.
- f) Keep ear dry
- g) Consider topical steroids if chronic eczematous problems.
- h) Oral antibiotics for auricular or systemic symptoms.

What to do:

- a) Keep ear dry
- b) Treat topically; clean ear if possible (Vo Sol HC, Decadron, etc.)
- b) Learn to insert ear wick; remove after 3-5 days
- c) Treat with appropriate analgesics

What not to do:

- a) Try and flush out the ear if otitis externa likely

E) Referral Guidelines

- a) Ear canal too swollen to allow eardrops (ok to insert wick)
- b) Inability to insert a wick
- c) Systemic symptoms
- d) Diabetic
- e) Immune suppression
- f) Copious debris or wax in the ear canal
- g) Progression of symptoms despite appropriate therapy

F) Comments

- a) Otitis externa is painful: treat with sufficient analgesics
- b) Always treat otitis externa topically
- c) Recurrent otitis externa
- d) Chondritis vs. otitis externa.

V. **Tonsillitis**

A) Evaluation

- a) Acute: physical exam, culture. Consider abscess if trismus or unilateral swelling exists.
- b) Chronic / Recurrent: document numbers and frequency of episodes.
- c) Differentiate between sore throat and tonsillitis.

B) Labs

- a) Throat culture, CBC, mono spot

C) Radiographs

- a) Not typically helpful

D) Management Options

- a) Pen. VK or amoxicilin (if not better in 48°, cover for pen resistant bugs)
- b) Cephalosporin
- c) Macrolide
- d) Clindamycin: excellent for difficult cases or early abscess / cellulitis

E) Referral Guidelines

- a) Suspected abscess
- b) Concern regarding obstruction (acute or chronic)
- c) Four (4) episodes in twelve (12) months
- d) Five (5) episodes in twenty-four (24) months
- e) Persistent Strep carrier
- f) Unilateral symptoms
- g) No response to medications
- h) Suspicion for neoplasm

What should accompany the referral:

- a) notes
- b) labs

F) Comments

- a) Consider systemic steroids for severe symptoms associated with mono
- b) “All” tonsil abscesses are anaerobic: consider Clindomycin or Flagyl early on
- c) For recurrent infections: advise frequent toothbrush change

VI. Nasal Obstruction

A) Evaluation

- a) History: Chronic vs. recurrent? Positional? Seasonal? History of nasal trauma?
Exam: External deformity, deviated septum, polyps, turbinate hypertrophy, tumor

B) Radiographs

- a) CT sinus if indicated for sinusitis
NOTE: CT sinus may underestimate nasal septal deflection.

C) Management Options

- a) Topical: Intranasal saline, intranasal steroids, and sodium cromolyn
- b) Systemic: Antihistamines for allergic rhinitis; decongestants for episodic obstruction.

What not to do:

- a) Intranasal decongestants for more than three (3) days.

D) Referral Guidelines

- a) Recent nasal trauma – refer within 3-4 days.
- b) Recurrent epistaxis
- c) Obvious deviated nasal septum, polyps, and turbinate hypertrophy
- d) Unresponsive to medications
- e) Associated persistent sinus symptoms
- f) Prior nasal trauma
- g) Suspicion for nasal septal hematoma
- h) Suspicion for tumor

E) Comments

- a) Simple anterior nasal exam may miss mid or posterior septal deflection or polyps. Refer to specialty for nasal endoscopy.

VII. Facial Paralysis (presumed Bell's Palsy)

A) Evaluation

- a) In absence of trauma (where immediate referral is necessary), exam should be done to rule out acute hearing loss or other neurologic signs of intracranial disease. Must watch for corneal irritation secondary to inability to close the eyes.

B) Labs

- a) CBC, Sed rate, Lyme titers?

C) Radiographs

- a) MRI after 1 (one) week if not improving (Gadolinium enhanced) - Call otolaryngologist before ordering MRI.

D) Management Options

- a) High dose steroids (1mg / kg / qd) for five (5) days, then decrease dosage over the next 10-14 days (if no contraindications.) If there are contraindications, no other medical management required except for eye drops (moisture).
- b) Antiviral agents? (Acyclovir)

What to do:

- a) Consider audiogram and eye care
- b) CT brain

What not to do:

- a) Antibiotics not indicated.

E) Referral Guidelines

- a) Total paralysis not responding to high dose prednisone for one (1) week. Refer to ENT for facial nerve testing and further evaluation. Should be seen within one (1) week.
- b) Urgent referral is chronic otitis media, acute otitis media, and hearing loss, trauma or external auditory canal vesicles.
- c) Childhood facial paralysis.

VIII. Epistaxis

A) Evaluation

- a) Unilateral vs. Bilateral?
- b) Anterior vs. Posterior?
- c) Bleeding diathesis or Hypertension?

B) Labs

- a) Coagulation studies only if systemic disorder suspected.

C) Radiographs

- a) none required

D) Management Options

- a) Saline nasal spray; Vaseline topically; direct nasal pressure; cotton ball

What to do:

- a) Stop Aspirin, Ibuprofen, Coumadin if severe bleeding

What not to do:

- a) Steroid nasal sprays

E) Referral Guidelines

- a) Bleeding is persistent, posterior, recurrent or severe.
- b) If a patient is on Coumadin.
- c) Patients with recent nasal trauma.
- d) If neoplasm is suspected.

What should accompany the referral:

- a) Labs if available

IX. Chronic Sinusitis

A. Evaluation

- a) Nasal, throat, neck, ear exam.

B. Labs

- a) CBC or WBC if febrile

C. Radiographs

- a) Waters / Caldwell views in limited situations. Screening CT preferred and necessary if four (4) episodes / year or continuous infection for 4-6 weeks.

D. Management Options

- a) Antibiotics x2 weeks per infection (4 weeks if Refractory)
- b) Decongestants (oral, nasal)
- c) Occasionally steroids (5-7 days) are helpful (and antibiotics)
- d) Mucolytics

What not to do:

- a) Use inappropriate antibiotics
- b) Too short a course of antibiotics

E) Referral Guidelines

- a) Infection (continuous) unresponsive to six (6) weeks of antibiotics
- b) 3-5 infections documented and treated per year
- c) CT scan evidence of significant disease after adequate treatment
- d) Complications such as cellulitis, meningitis, etc... (orbital)
- e) Prior sinus surgery with continuous infections
- f) Suspected fungal infection
- g) Intolerance to antibiotics

What should accompany the referral:

- a) CT scan, any labs, history and antibiotic use

F) Comments

- a) Use different antibiotics rather than single one over and over.
- b) Attempt deep nasal culture after antibiotic failure. (Otolaryngologist to do)
- c) Repeat CT scan after extended antibiotic course to assess success of treatment prior to referral if symptoms persist.

X. OME (Otitis Media with Effusion / Serous Otitis)

A) Evaluation

- a) Clinical Exam:
 - 1) retraction of Tympanic membrane
 - 2) dull appearance
 - 3) decreased mobility on pneumotoscopy
 - 4) visible fluid, bubbles, meniscus, etc....
 - 5) evidence of hearing loss
 - 6) evidence of speech & language development

B) Labs

- a) Tympanogram / Audio screen if available in PCP office

C) Radiographs

- a) None

D) Management Options

- a) Treat after twelve (12) weeks of duration with at least four (4) weeks of antibiotics.

What to do:

- a) Environment – avoid 2nd hand smoke

What not to do:

- a) Decongestants, antihistamines, nasal steroids

E) Referral Guidelines

- a) Documented or suspected duration of bilateral OME x3 months, despite treatment of four (4) weeks of antibiotics.
- b) Hearing loss of more than 20 decibels for more than four (4) weeks.

What should accompany the referral:

- a) Clinical notes documenting exams, prior treatment and any Tympanogram

XI. Chronic Otitis Media

A) Evaluation

- a) Persistent effusion or negative middle ear pressure with or without recurring acute otitis media
- b) Audiogram if suspected hearing loss, persistent effusion
- c) Look for perforation, retraction pockets, or drainage

B) Labs

- a) Culture drainage

C) Management Options

- a) Up to three (3) courses of antibiotics (covering Strep pneumo, H flu and M. cat) ten (10) days each, at least one (1) course of beta-lactam resistant antibiotic

What not to do:

- a) Decongestants & antihistamines have not been shown to be beneficial for Otitis

D) Referral Guidelines

- a) Failure of medical management
- b) Perforation
- c) Suspected cholesteatoma or mastoiditis
- d) Facial palsy (an urgent referral)
- e) Vertigo
- f) Persistent hearing loss greater than 2-3 months
- g) Persistent unilateral findings in an adult
- h) Severe retraction

What should accompany the referral:

- a) Antibiotic history
- b) Audiogram

XII. Vertigo

A good history and neurological exam by the primary care physician will often make a diagnosis. Dizzy patients often present with an array of confusing complaints and need help organizing these. In general the patient's symptoms can be placed into the following categories:

- A) Vertigo: A subjective or objective sense of movement often rotary in nature; usually related to a peripheral Labyrinthine cause.

- B) Loss of equilibrium often described as “almost falling” or “my balance is off”; the etiology may be abnormalities in the cerebrum, cerebellum, pyramidal track, posterior column, or peripheral system.
- C) Light-headedness: A feeling often related to quick positional changes; usually a vascular etiology.
- D) Dizziness. A disturbed sense or relationship to space in which the etiology may be vestibular, cerebellar, visual, hematologic, or gastrointestinal.

Describe the initial episode in detail; start of symptoms, activities being performed, duration continuous or intermittent, frequency, what brings on the symptoms, symptoms occurring after the attack.

The following information should also be investigated:

- A) Associated otologic complaints such as hearing loss-progressive vs. fluctuating, tinnitus, aural fullness, otalgia, otorrhea, or facial paralysis.
- B) Previous otologic surgery, head trauma, or noise exposure.
- C) Medication history and use of ototoxic and/or vestibulotoxic medication
- D) Family history of otosclerosis, neurofibromatosis, etc.
- E) Complete medical history to evaluate the possibility of diabetes, hypothyroidism or hyperthyroidism, cardiovascular disease, eye disease such as cataracts autoimmune disease, and a history of infectious diseases such as syphilis. *
- F) Central nervous system symptoms such as loss of consciousness, seizure activity, confusion, memory loss, peripheral weakness, numbness, dysphagia and double, blurred, or loss of vision. *

* Suggests central disorder that causes vertigo. (Neurology consultation may be appropriate)

Physical exam must always include a full neurological exam and middle ear exam and gross hearing assessment.

***Emergency otolaryngology referrals (24 hours)**

- A) Chronic draining ear with acute onset severe vertigo. (possible cholesteatoma with labyrinthine erosion – requires surgery)
- B) Acute otitis media with severe vertigo. (possible acute suppurative labyrinthitis – requires surgery and IV antibiotics)
- C) Trauma directly to the ear with acute hearing loss and vertigo. Examples: Q-tip injury to the tympanic membrane, acute barotrauma (scuba diving injury), strong valsalva (weight lifting). (Possible perilymphatic fistula – benefits from surgical exploration if conserving measures fail such as bed rest with head elevation, avoiding any lifting, straining or nose blowing)

***Urgent otolaryngology referrals (48-72 hours)**

Trauma to the head with acute hearing loss and vertigo
(Possible temporal bone fracture, usually no immediate surgery, observe for CSF leak)

*Peripheral Vestibular Disorders

Meniere's Disease

- A) Evaluation – Episodic true vertigo, fluctuating hearing loss (usually low frequency), tinnitus in the affected ear (often fluctuating or even crescendo prior to attacks), and the sensation of aural pressure in the involved ear.
- B) Management – Obtain audiogram if complaints of hearing loss at the time of the visit. May treat vertigo symptomatically. Meclizine, etc. Refer to drug sheet.
- C) Referral – Elective Otolaryngology referral. Please refer to general medical evaluation on page one. Forward records, labs, EKG, etc. with referral slip.

Labyrinthitis

- A) Evaluation – Viral is the most common form, often preceded by a viral infection of the upper respiratory or GI tract by as much as 2 weeks. Symptoms onset – severe true vertigo exacerbated by head movement. If present, get an audiogram. On neurological exam ocular nystagmus will be present in the acute phase, otherwise normal neurological exam and ear exam. Severe symptoms last about 72 hours with gradual return to normal balance over 6-8 weeks.
- B) Management – Symptomatic medications.
- C) Referral – Otolaryngology referral if patient has an abnormal ear exam, or hearing loss, or if symptoms last longer than 8 weeks. Please refer to medical evaluation on page one. Forward records, labs, EKG, etc. with referral slip.

Benign Paroxysmal Positional Vertigo (BPPV)

- A) Evaluation – Onset of true vertigo rapidly brought about by assuming very specific head positions (neck extension with head turned to one side or rolling to one side in bed – examples). Vertigo lasts 1-2 minutes. No associated hearing loss, aural fullness, or tinnitus. This is very common in the elderly, or any age group after mild head trauma. Obtain an audiogram to confirm no asymmetry. Dix hallpike will often be abnormal, but not always. The dependant ear is the diseased ear.
- B) Management – Usually self-limited, commonly resolving in 6-12 months. Usually vestibular suppressive medications are not needed.
- C) Referral – If patient is functionally debilitated, or in high-risk profession (roofer, painter), or if symptoms persist more than 6 months, or if abnormal/asymmetric audiogram, refer to Otolaryngology. Vestibular habituation exercises, or vestibular positioning procedures (Eply/Semont) are often helpful. Please refer to page one. Forward records, labs, EKG, etc. with referral slip.

Vestibular Neuronitis

- A) Evaluation – Controversy exists, is this neuronitis or a form of chronic labyrinthitis: (recurrent viral infection?) The affected patient is prone to episodic exacerbation with vertigo symptoms unaccompanied by aural pressure, hearing loss or tinnitus.
- B) Management – Confirm normal audiogram. Symptomatic medications.
- C) Referral – Usually proceed with otolaryngology referral due to the recurrent nature of the symptoms after a complete medical evaluation to address possibility of diabetes, hypo-hyperthyroidism, cardiovascular disease, eye disease, autoimmune disease, or infectious disease such as syphilis. Please forward these records with referral slip.

Autoimmune Vestibulopathy

- A) Evaluation – Progressive bilateral hearing loss often accompanied by a bilateral loss of vestibular function. Other autoimmune mediated disease is often present (rheumatoid arthritis, psoriasis, ulcerative colitis, Cogan’s syndrome-iritis, vertigo, and hearing loss). Obtain appropriate autoimmune metabolic tests.
- B) Management – Must treat the underlying disease process. Steroids, cytotoxic agents, plasmapheresis.
- C) Referral – Primary referral is to rheumatologist. Otolaryngologist will assist in evaluation by following improvement of hearing with therapy, and confirming absence of any other associated pathology.

Central Vestibular Disorders

Vascular Disorder

Vertebrobasilar insufficiency (VBI)

- A) Evaluation – 4 D’s – dizziness, diplopia, dysphagia, drop attacks. Rapid onset vertigo with nausea, emesis lasting several minutes. Associated symptoms include visual changes “brown out”; drop attacks, visual field defects, diplopia, and headaches. May be precipitated by orthostatic hypotension or mechanical compression.
- B) Management – Full cardiovascular evaluation.
- C) Referral – Referral to otolaryngology only if requested by Cardiology or neurology, or if asymmetric hearing loss.

Posterior Fossa Migraine

- A) Evaluation – Caused by ischemia in the distribution of the basilar artery (occipital and posterior temporal lobes). Symptoms include diplopia, tinnitus, vertigo, dysarthria, and rarely, hearing loss. Results from dysfunction of CN III-XII. Sensorimotor signs of weakness drop attacks, paresthesia of extremity or face, even syncope. May be confused with **Peripheral Vestibular Disorder** since vertigo onset is abrupt, lasting 5-6 minutes. Headache that follows can be mild and overlooked as a symptom by the patient.
- B) Management – Detailed history and neurological exam.
- C) Referral – Referral to Neurology.

Vasocclusive Disease

- A) Evaluation – Differentiated from **Peripheral Vestibular Disorder** by presence of associated findings of central injury.
 - a) Lateral Medullary Syndrome (AICA infarct) – Vertigo, nausea, ataxia, ipsilateral Horner’s syndrome, loss of pain and temperature to ipsilateral face and contralateral body, ipsilateral palatal, pharyngeal, laryngeal paralysis.
 - b) Cerebellar Infarct – severe vertigo, nausea, emesis, ataxia. Distinguishing features are gait and extremity ataxia.
 - c) Cerebellar Infarct – Most common in the elderly patient with history of hypertension and vascular disease. Patients complain of imbalance.
- B) Management – Detailed history and neurological exam.
- C) Referral – Referral to Neurology.

Multiple Sclerosis

Vertigo will occur as an initial symptom in only 5% of patients.

CNS Neoplasm

- A) Evaluation – Acoustic neuroma/vestibular schwannoma. Unilateral or asymmetric sensorineural hearing loss, unilateral tinnitus, asymmetric audio discrimination scores, +/- facial numbness or tingling, +/- acute vertigo.
- B) Management – Proceed with full detailed audiogram, ear exam, and neurological exam.
- C) Referral – Referral to otolaryngology if suspect. Imaging will be ordered by otolaryngologist if necessary. ABR's are rarely ordered (low sensitivity makes hearing conservation surgery difficult).

***Agents for Vertigo (Use with caution in the elderly)**

Meclizine HCL 25 mg. PO q 6-8 hrs (This is OTC)

Hydrochlorothiazide 25 mg. PO q day (for Meniere's Disease)

Phenergan 25 mg PO qid

Valium 2 mg PO qid (usually reserved for severe vertigo, occasionally need doses of 2-10 mg)

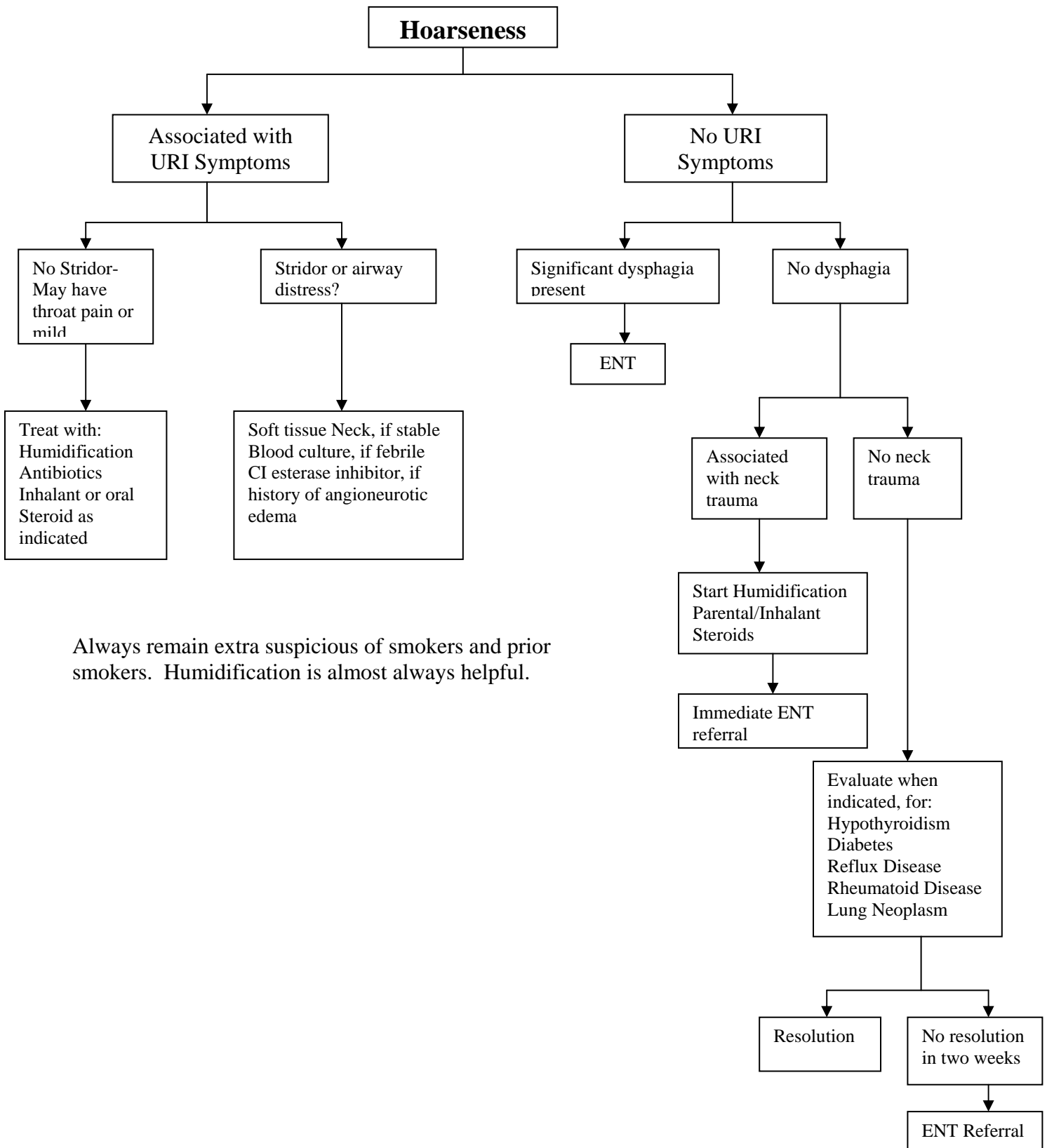
Reglan 10 mg PO qid

Tigan 200 mg PR q 6-8 hrs (suppository)

Scopolamine patch 1 patch behind the ear, change q 3 days, prn

Note – Symptomatic treatment may prolong the recovery period.

XIII. Hoarseness



XIV. Sialoadenitis

A) Evaluation

Hx of pain in parotid or submandibular glands, enlargement, Possible fever, exacerbation with eating. Possible sudden onset with food intake. Associated with dehydration or rarely sicca complex. PE: enlargement of parotid or submandibular (bimanual floor of mouth palpation) gland, pain, murky or no fluid from Stenson's or Wharton's ducts. May be able to palpate stone in duct or mass.

B) Labs: None

C) Radiographs: None

D) Management Options: Antistaphylococcal antibiotic (cephalexin, dicloxacillin, Clindamycin). Massage gland firmly and frequently to express saliva, warm compress, sialogogues (lemon drops, pickles) stimulate saliva flow, hydration, antipyretic, pain reliever. F/U exam to ensure complete resolution.

What to do:

- a) Advise patient to call or return in a couple of days if no improvement.

What not to do:

- a) Assume that any residual nondularity or mass is not a tumor.

D) Referral Guidelines: Failure to resolve, very toxic patient, residual mass or nodularity, palpable stone, pointing abscess, elevation of floor of mouth (Ludwigs Angina – emergency). Facial Nerve paresis (emergency). Recurrent problem.

What to accompany referral

- a) Notes on prior treatment if patient difficult historian.

XV. Sleep Apnea – Rule out/Evaluation

A) Evaluation

- a) Indications for obtaining a sleep study.
 - 1) Witnesses apnea of worrisome nature
 - 2) Excessive daytime fatigue / sleepiness
 - 3) Narcolepsy like symptoms
 - 4) Frequent nocturnal arousal's

B) Management Options

- a) PCP to order and review sleep study results before considering ENT referral. Weight loss program if indicated.
- b) Management of nasal obstruction if indicated.

What to do:

- a) One (1) month of C-PAP trial if sufficient sleep apnea on sleep study.

C) Referral Guidelines

- a) ENT referral if:

- 1) sleep apnea unrelieved by C-PAP
 - 2) patient intolerant to C-PAP
 - 3) significant upper respiratory anatomic problems
- D) What should accompany the referral – sleep study report
- a) Criteria for Sleep Study
The possibility of Obstructive Sleep Apnea should be considered when there is history of either 1 or 2 below:
 - 1) Observed periods of apnea, choking or breathing irregularities during sleep.
 - 2) Unexplained excessive daytime sleepiness that interferes with the activities of daily living.
 - 3) Snoring (this alone is not enough)
 - 4) Neck size greater than 16” (41 cm) in females or 17” (43 cm) in males. This is the physical finding most predictive of Obstructive Sleep Apnea.
 - 5) Hypertension.

*3, 4, & 5 above are for confirmation only.
- E) Comments
- a) Snoring without sleep apnea is a non-covered medical condition
 - b) Referral for snoring without documented apnea (by sleep study) is not a covered benefit
- F) Treatment of Obstructive Sleep Apnea (OSA)
- a) CPAP (Continuous Positive Airway Pressure) – PCP can order if symptoms include excessive daytime sleepiness plus one of the following:
 - 1) RDI (Respiratory Distress Index) >10
 - 2) Recurrent desaturation below 88%
 - 3) UARS (Upper Airway Resistance Syndrome) as evidence by numerous arousals associated with increasing respiratory effort and/or increasingly negative esophageal pressures.
 - b) Uvulopalatopharyngoplasty (UPPP): Approved after failure of CPAP trial
 - c) Laser-Assisted Uvulopalatoplasty (LAUP): Not an approved procedure.
 - d) Radiofrequency Volume Reduction (Somnoplasty of the Palate): considered investigational for OSA.

This guideline is based on references listed. The guideline is not mandatory but has been approved by the SPA QM/UM Committee, and is intended to assist clinicians and to positively impact the quality of care. However, the guideline is presumptive only, and the judgement and experience of the treating physician, as applied to the specific facts of each case, are the final determinants of patient care. The guideline is intended for physician use only, and is not intended to be provided to patients.

APPROVAL:



SPA / SMF Medical Director

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Date

Revisions / Approval Summary:

SMF QM Committee
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